IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

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BUREAU OF FACILITY STANDARDS
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July 23, 2010

Teresa Carpenter
Preferred Community Homes - Cornerstone
615 2nd Avenue West
Wendell, ID 83355

RE: Preferred Community Homes - Cornerstone, provider #13G056

Dear . Carpenter:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Cornerstone, which was conducted on July 16, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **August 4, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by August 4, 2010. If a request for informal dispute resolution is received after August 4, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Trish O'Hara

TRISHA O'HARA
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

TO/srp

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G056	A. BUILDING _____ B. WING _____	07/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - CORNERSTONE	2028 EAST 2975 SOUTH WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Trish O'Hara, RN - Team Lead Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record QMRP - Qualified Mental Retardation Professional RN - Registered Nurse	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Cornerstone with the facts, findings or other statements as alleged by the state agency dated July 16, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Cornerstone – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure the individual program plan described relevant interventions to support independence for 1 of 4 individuals (Individual #2) whose IPPs were reviewed. This resulted in the insufficient information being available to staff related to an individual's supervision needs. The findings include: 1. Individual #2's 4/29/10 IPP stated he was a 15 year old male whose diagnoses included	W 240	**W 240 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN** All Individual Program Plans will be reviewed and revised to ensure that specific information related to their needs is included in the IPP document. The Assistant QIDP will be responsible and the QIDP will monitor and review all IPP's to ensure compliance with this regulation. Core team meetings will be conducted quarterly to review and monitor all residents IPP documents. Person Responsible- AQIDP. Completion Date- 10/08/2010. Monitoring- Quarterly.	

RECEIVED
AUG 30 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tom Mills	Administrator	8/26/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 240	Continued From page 1 profound mental retardation and seizure disorder. During observations conducted at the facility on 7/13/10 from 5:40 - 7:20 a.m., 10:05 - 10:55 a.m., and 2:30 - 3:00 p.m., Individual #2 was observed to have one staff working with him at all times. The staff was not observed to leave Individual #2's side. Individual #2's record included a General Information sheet, undated, which stated Individual #2 "is one on one staff/client ratio." However, no additional information could be found in the record, and the IPP did not include information related to Individual #2's need for one on one staffing. During an interview on 7/16/10 from 11:25 a.m. - 12:15 p.m., the Administrator stated Individual #2 required increased one on one staff supervision due to his medical concerns. The QMRP, who was present during the interview, stated Individual #2's one on one needs had not been included in the IPP. The facility failed to ensure Individual #2's IPP included specific information related to his one on one supervision needs.	W 240		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by:	W 262		

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W 262	Continued From page 2 Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 1 of 3 individuals (individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior approvals of restrictive interventions. The findings include: 1. Individual #1's 2/16/10 IPP stated he was a 15 year old male whose diagnoses included severe mental retardation, autism, neuro motor disfunction, and microcephaly. Individual #1's dental record, dated 8/11/09, stated "one assistant helped hold pt. [patient]." A dental record, dated 2/16/10, stated "1 assistant." Individual #1's Written Informed Consent, dated 3/9/10, stated he required physical restraint, including staff holding his head, legs, torso and hands as needed during dental visits. The consent did not include HRC approval. No additional documented consent was found in Individual #1's record. During an interview on 7/16/10 from 11:25 a.m. - 12:15 p.m., the Administrator stated Individual #1 did require restraint during dental procedures and HRC approval for the restraint had not been obtained due to an oversight. The facility failed to ensure HRC approval was obtained prior to the use of restraint during dental procedures for Individual #1.	W 262	**W 262 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE** The AQIDP will receive training in regards to the policy and procedures for restrictive intervention and the requirement for HRC approval prior to program implementation, specifically in regards to dental and medical appointments. The Assistant to the Regional Representative has been assigned to monitor the facility by doing observations and book reviews to ensure regulation compliance. HRC approval will be obtained for all restrictive interventions. All individual's consents will be reviewed to ensure that HRC approval has been obtained prior to use. All individual's consents will be reviewed at a quarterly core team meeting to ensure that are not outdated or invalid. Person Responsible- AQIDP. Completion Date- 10/08/2010. Monitoring- Quarterly.	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE	W 263		

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W 263	Continued From page 3 The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the parent/guardian for 1 of 3 individuals (Individual #1) whose restrictive interventions were reviewed. This resulted in a lack of protection of an individual's rights through prior consent for restrictive interventions. The findings include: 1. Individual #1's 2/16/10 IPP stated he was a 15 year old male whose diagnoses included severe mental retardation, autism, neuro motor disfunction, and microcephaly. Individual #1's dental record, dated 8/11/09, stated "one assistant helped hold pt. [patient]." A dental record, dated 2/16/10, stated "1 assistant." Individual #1's Written Informed Consent, dated 3/9/10, stated he required physical restraint, including staff holding his head, legs, torso and hands as needed during dental visits. The consent was signed by Individual #1's guardian on 4/30/10, which was after the dental appointments had taken place. No previous consent was found in Individual #1's record. During an interview on 7/16/10 from 11:25 a.m. - 12:15 p.m., the Administrator stated Individual #1 did require restraint during dental procedures and guardian consent for the restraint had not been	W 263	**W 263 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE** The AQIDP will receive training in regards to the policy and procedures for restrictive intervention and the requirement for Guardian approval prior to program implementation, specifically in regards to dental and medical appointments. The Assistant to the Regional Representative has been assigned to monitor the facility by doing observations and book reviews to ensure regulation compliance. Guardian approval will be obtained for all restrictive interventions. All individual's consents will be reviewed to ensure that Guardian approval has been obtained prior to use. All individual's consents will be reviewed at a quarterly core team meeting to ensure that they are not outdated or invalid. Person Responsible- AQIDP. Completion Date- 10/08/2010. Monitoring- Quarterly.	

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W 263	Continued From page 4 obtained due to an oversight. The facility failed to ensure guardian consent was obtained prior to the use of restraint during dental procedures for Individual #1.	W 263		
W 303	483.450(d)(4) PHYSICAL RESTRAINTS A record of restraint checks and usage must be kept. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records documented a clear understanding of the events before, during, and after the use of restraint for 1 of 1 individuals (Individual #1) whose records documented the use of restraints. Failure to keep a comprehensive record of restraint usage impeded the IDT's, the facility's HRC, and an individual's guardian's ability to make informed decisions and/or recommendations regarding the use of restraint. Findings include: 1. Individual #1's 2/16/10 IPP stated he was a 15 year old male whose diagnoses included severe mental retardation, autism, neuro motor disfunction, and microcephaly. Individual #1's dental record, dated 8/11/09, stated "one assistant helped hold pt. [patient]." A dental record, dated 2/16/10, stated "1 assistant." However, Individual #1's record did not contain additional information regarding the use of restraint during dental, i.e. time in, time out, type of restraint, etc. During an interview on 7/16/10 from 11:25 a.m. -	W 303	**W 303 483.450(d)(4) PHYSICAL RESTRAINTS** **Facility will implement a record of restraints during all medical appointments including dental. This will include: date, procedure, in time, out time, type of support/restraint, duration of support/restraint, whether or not a reduction plan is in place/attempted, the location of the support/restraint, the success of the support/restraint. Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents.** **Person Responsible- LPN and Registered Nurse. Completion Date- 10/08/2010. Monitoring- Quarterly.**	

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W 303	Continued From page 5 12:15 p.m., the Administrator stated Individual #1 did require restraint during dental procedures, but records of restraint for the 8/11/09 and 2/16/10 dental appointments did not exist due to an oversight. The facility failed to ensure the use of restraint for Individual #1's dental procedures were documented to present a clear understanding of the events prior to, during, and following its use.	W 303		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure adequate general and preventative medical care was provided to 1 of 1 individuals (Individual #4) who required medications, hydration, and nutrition through the use of a G-tube. This resulted in the potential for an individual's health needs to not be met. The findings include: 1. Individual #4's 9/17/09 IPP stated he was an 18 year old male whose diagnoses included profound mental retardation, seizure disorder, scoliosis, and blindness. He was non-verbal, required the use of a wheelchair for mobility, and the use of a G-tube (gastrostomy tube - a tube that is surgically placed into the stomach through the abdominal wall) for medications, hydration, and nutrition. Individual #4's Nutrition Progress Notes, dated	W 322	**W 322 483.460(a)(3) PHYSICIAN SERVICES** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. The RN will also do documented observations to verify that all of the hydration and tube feeding needs are being met. Staff training will occur on tube feeding and flushing schedules of residents with G-tube. Person Responsible- LPN and Dietitian. Completion Date- 10/08/2010. Monitoring- Weekly.	

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W 322	Continued From page 6 12/3/09, stated his fluid needs were up to 1700 cc's with tube feeding and flushes providing 1500 - 1700 cc's. A Nutrition Progress Note, dated 3/25/10, stated Individual #4 was to receive Carnation Instant Breakfast (CIB), 1 can three times daily, which provided 582 cc's of water. Individual #4's MAR documented he was to receive the following: - 30 cc water prior to each medication pass (done three times daily), for a total of 90 cc. - 30 cc water at the end of each medication pass, for a total of 90 cc. - 30 cc water before each can of CIB (given three times daily), for a total of 90 cc. - 30 cc water after each can of CIB, for a total of 90 cc. - 200 cc of water three times daily, for a total of 600 cc. Per Individual #4's MAR, he was to receive 960 cc water in flushes, plus the 582 cc of water provided by the CIB for a total of 1542 cc water, falling within the 1500 - 1700 cc required per his Nutrition Progress Note. However, during an observation on 7/13/10 from 5:40 - 7:20 a.m., Individual #4 was observed during medication administration. The staff provided a 30 cc flush with water, medications mixed in applesauce, 1 can CIB, and a final 30 cc flush with water. Staff was not observed to provide a water flush before and after both medications and CIB. Doing so would decrease Individual #4's water consumption by 60 cc each medication and CIB administration. As a result, Individual #4 could only be guaranteed of	W 322		

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W 322	Continued From page 7 receiving 1352 cc of water, well below the 1500 - 1700 cc range established by the dietician. During a telephone interview on 7/15/10 from 3:00 - 3:07 p.m., the Dietician stated the fluids as outlined on the MAR would meet Individual #4's minimum requirements. The Dietician stated the fluids received as observed would not be sufficient to meet Individual #4's requirements. During an interview on 7/16/10 from 11:25 a.m. - 12:15 p.m., the LPN stated Individual #4 should not be receiving CIB during medication administration. The LPN stated Individual #4's fluid flushes should be administered as per the MAR. The facility failed to ensure Individual #4's hydration and tube feedings were completed as per his needs.	W 322		
W 363	483.460(j)(2) DRUG REGIMEN REVIEW The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure irregularities in individuals' drug regimens were reported to the prescribing physician and IDT by the pharmacist for 1 of 4 individuals (Individual #2) whose pharmacy records were reviewed. This resulted in the physician and IDT not being informed of an individual receiving a medication for which a physician's order had not been obtained. The findings include:	W 363		

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W 363	Continued From page 8 1. Individual #2's 4/29/10 IPP stated he was a 15 year old male whose diagnoses included profound mental retardation and seizure disorder. Individual #2's 12/09 MAR stated he received guaifenesin (a respiratory tract drug) 400 mg on 12/19/09. However, Individual #2's record did not contain a physician's order for the use of guaifenesin. Individual #2's pharmacy reviews, dated 12/22/09 and 3/18/10, did not include documentation of Individual #2 receiving unprescribed medications. The pharmacist failed to identify the medication errors and report to the physician. During an interview on 7/16/10 from 11:25 a.m. - 12:15 p.m., the Administrator stated the facility's LPN took individuals' medical records to the facility's corporate office for review by the pharmacist. At that time, the pharmacist was to review all documentation in the medical record including individuals' MAR and physician's orders. The Administrator stated she did not know how the unprescribed medication was overlooked. The facility failed to ensure the pharmacist reported Individual #2's receipt of an unprescribed drug to the physician and IDT.	W 363	**W 363 483.460(j)(2) DRUG REGIMEN REVIEW** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. Doctors' orders will be obtained for all medications given to residents. Pharmacist will do quarterly reviews of all medication. RN will follow pharmacist review with her own review. Person Responsible- Physician, Registered Nurse, and Pharmacist. Completion Date- 10/08/2010. Monitoring- Quarterly.	
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure all	W 368		

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W 368	Continued From page 9 medications were administered in compliance with physician's orders for 1 of 4 individuals (Individual #2) whose medication administration records were reviewed. This resulted in an individual receiving a medication that had not been ordered by the physician. The findings include: 1. Individual #2's 4/29/10 IPP stated he was a 15 year old male whose diagnoses included profound mental retardation and seizure disorder. Individual #2's 12/09 MAR stated he received guaifenesin (a respiratory tract drug) 400 mg on 12/19/09. However, Individual #2's record did not contain a physician's order for the use of guaifenesin. During an interview on 7/16/10 from 11:25 a.m. - 12:15 p.m., the LPN stated Individual #2 did not have an order for the use of guaifenesin. The facility failed to ensure Individual #2's medications were given in compliance with physician's orders.	W 368	**W 368 483.460(k)(1) DRUG ADMINISTRATION** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. Doctors' orders will be obtained for all medications given to residents. Pharmacist will do quarterly reviews of all medication. RN will follow pharmacist review with her own review. Person Responsible- Physician, Registered Nurse, and Pharmacist. Completion Date- 10/08/2010. Monitoring- Quarterly.	
W 382	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all drugs and biologicals were maintained under locked conditions for 8 of 8 individuals (Individuals #1 - #8) residing at the facility. This resulted in the	W 382		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 382	Continued From page 10 potential for harm in the event individuals accessed and ingested a drug. The findings include: 1. An observation was conducted at the facility on 7/13/10 from 5:40 - 7:20 a.m. During that time, individuals were observed to be assisted with medication administration. At 6:06 a.m., Individual #1 entered the medication administration area. The staff assisting with medication administration was observed to dispense Individual #1's medications into a small medication cup. The staff handed Individual #1 the medication cup. While taking his medications, Individual #1 was observed to drop one pill of cetirizine HCL (an antihistamine drug) 10 mg. The pill landed on the floor next to the toilet. The staff wrapped the pill in toilet paper and threw it in the garbage. Individual #1 completed his medication administration routine at 6:20 a.m. Between 6:20 a.m. and 7:10 a.m., the staff present left the room on 4 different occasions, leaving the garbage can, and therefore the pill, unsecured. The LPN, who was present during the observation, was interviewed at 7:10 a.m. The LPN stated staff should have disposed of the pill by flushing it down the toilet. The pill was retrieved from the garbage by the LPN and flushed down the toilet at 7:20 a.m. During a telephone interview on 7/15/10 from 3:25 - 3:40 p.m., the facility's RN stated pills could be disposed of in the sharps container, by flushing down the toilet, or by putting them down	W 382	**W 382 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. In addition, an additional RSC is being hired for the home. This will provide additional supervision and training for the staff in the home. All staff will be trained on proper disposal of medications and the drug destruction policy, the Medication Administration Policy, and the Federal regulation of drug storage and recordkeeping . Person Responsible- LPN will do random SAMs observations monthly. Completion Date- 10/08/2010. Monitoring- monthly.	

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	13G056	A. BUILDING _____ B. WING _____	07/16/2010

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W 382	Continued From page 11 the garbage disposal. The RN stated throwing a pill in the garbage can was not an acceptable form of disposal. The facility failed to ensure all drugs were locked except when being administered.	W 382		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure directly impacted 3 of 4 individuals (Individuals #1, #2, and #4) observed during medication administration, and had the potential to impact all individuals (Individuals #1 - #8) residing in the facility. This had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. An observation was conducted at the facility on 7/13/10 from 5:40 - 7:20 a.m. During that time, individuals were observed to be assisted with medication administration. The following infection control issues were noted during the observation: a. At 6:06 a.m., Individual #1 entered the medication administration area. The staff assisting with medication administration was observed to dispense Individual #1's medications into a small medication cup. Individual #1's Gummy Vites (a supplement drug) were noted to	W 455	**W 455 483.470(I)(1) INFECTION CONTROL** Preferred Community Homes has assigned a Registered Nurse to support and provide training to the LPN. The RN will monitor the nursing records quarterly to verify regulation compliance and be available for the LPN to assist with the needs of the residents. The facility's orientation practices are being revised to include training for infection control needs. All staff will be trained on infection control in relation to medication passes and the appropriate handling of medications which will include topicals as well as oral medications. The LPN will be doing at least monthly SAM observations to verify infection control practices are being used. In addition the assigned RN will be doing quarterly SAM observations as well and will verify that infection control practices are appropriate. Person Responsible- LPN will do random SAMs observations monthly. Completion Date- 10/08/2010. Monitoring- monthly.	

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W 455	Continued From page 12	W 455		

be in a large bottle. Staff used her bare finger to pull two of the vitamins out of the bottle and place them into the medication cup.

The staff handed Individual #1 the medication cup. While taking his medications, Individual #1 was observed to drop one pill of cetirizine HCL (an antihistamine drug) 10 mg. The pill landed on the floor next to the toilet. The staff assisting with the medication administration program picked up the dropped pill with a bare hand, used toilet paper to wipe off the pill, and proceeded to hand the pill to Individual #1 to take. At that point, the Surveyor interrupted the medication administration process and asked the staff about the facility's procedure for dropped medications. The staff stated she did not know.

The facility's LPN, who was present in another area of the facility, was called into the medication administration area and directed the staff to dispose of the dropped pill and provide Individual #1 with a new pill.

b. At 6:20 a.m., Individual #2 entered the medication administration area. The staff was observed to use her bare hands to apply clindamycin phosphate (an anti-infective drug) to Individual #2's cheeks. The staff then used her bare hands to apply Equate dry skin cream to Individual #2's hands. Staff did not wash her hands between the applications of clindamycin phosphate to Individual #2's cheeks and the application of the skin cream skin cream.

c. At 6:37 a.m., Individual #4 entered the medication administration area. Individual #4 received his medications and feedings through a G-tube (gastrostomy tube - a tube that is

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W 455	Continued From page 13 surgically placed into the stomach through the abdominal wall). Staff used her bare hands to open a split sponge (a type of wound dressing), used a bare finger to wipe a small amount of Fougera triple antibiotic ointment from the tube and apply to the sponge. The staff applied the sponge around Individual #4's G-tube stoma site. The staff then used her bare hands to apply Equate dry skin cream to Individual #4's face. The staff did not wash her hands between application of the triple antibiotic ointment to the stoma site and the application of the dry skin cream. The LPN, who was present during the observation, was interviewed at 7:10 a.m. The LPN stated staff are not supposed to give individuals pills that have been dropped on the floor. When asked if staff should have bare hand contact with individuals' pills or topical medications, the LPN stated they could if they had washed their hands. During a telephone interview on 7/15/10 from 3:25 - 3:40 p.m., the facility's RN stated staff should not give pills that had been dropped on the floor. The RN stated staff should not handle individuals' pills with their bare hands, and should not apply topical medications with their bare hands. The facility failed to ensure proper infection control procedures were followed during medication administration programs.	W 455		

Bureau of Facility Standards

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MM182	16.03.11.075.09 (a)(iv) Resident placed in Restraints The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following: A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and This Rule is not met as evidenced by: Refer to W303.	MM182	**MM 182 16.03.11.075.09(a)(iv) RESIDENT PLACED IN RESTRAINTS** Please refer to W 303	
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	**MM 194 16.03.11.075.10(a) APPROVAL OF HUMAN RIGHTS COMMITTEE** Please refer to W 262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	**MM 196 16.03.11.075.10(c) CONSENT OF PARENT OF GUARDIAN** Please refer to W 263	
MM262	16.03.11.100.01(c) Private Water Supply examination If water is from a private supply, water samples must be submitted to the Department through the District Public Health Laboratory for bacteriological examination at least once every	MM262		

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MM262	Continued From page 1 three (3) months. Copies of the laboratory reports must be kept on file at the facility. This Rule is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure water samples were submitted for bacteriological examination at least quarterly for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This had the potential to negatively impact individuals' health. The findings include: 1. The facility had a private well for potable water. A review of the facility's water test results documented the most recent water test had been completed on 7/13/06. No additional testing was found. During an interview on 3/15/10 at 2:35 p.m., the Residential Service Coordinator (RSC) stated she was responsible for completing the water tests. The RSC stated tests were to be conducted quarterly, but she would forget to do so. The facility failed to ensure quarterly bacteriological water examinations were completed.	MM262	**MM 262 16.03.11.100.01(c) PRIVATE WATER SUPPLY EXAMINATION** The RSC will ensure quarterly bacteriological water examinations are completed and submitted to the Department through the local public health laboratory. A tracking sheet will be developed and monitored by the program Administrator quarterly to verify that the water examinations are submitted. Person Responsible- RSC. Completion Date- 10/08/2010. Monitoring-QIDP, Quarterly.	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all toxic chemicals were properly labeled and stored under lock and key for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals, and unidentified chemicals to be misused. The findings include:	MM271		

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MM271	Continued From page 2 1. During an environmental review on 7/15/10 from 11:05 - 11:30 a.m., the following toxic chemicals were found to be unlocked under the kitchen sink: - A 1.4 gallon bottle of Clorox Clean Up with Bleach. - A 1 quart bottle of Clorox Clean Up with Bleach. - A can of Sprayway Glass Cleaner. The MSDS (Material Safety Data Sheet) for Clorox Clean Up with Bleach stated the product could irritate skin, eyes, nose, throat, and lungs, and was harmful if swallowed. The MSDS for Sprayway Glass Cleaner stated the product was classified as a "Hazardous Chemical" and was harmful to skin, kidneys, blood, and liver. The Residential Service Coordinator (RSC), who was present during the review, stated the chemicals should have been locked. The facility failed to ensure all toxic chemicals were maintained under locked conditions. 2. During an environmental review on 7/15/10 from 11:05 - 11:30 a.m., the following chemicals were found to be unlocked and unmarked: - An unlabeled spray bottle containing a blue liquid was found in an unlocked cabinet under the kitchen sink. - An unlabeled spray bottle containing a blue liquid was found in an unlocked cabinet in the laundry room. The RSC, who was present during the review,	MM271	**MM 271 16.03.11.100.04(b) STORAGE OF TOXIC CHEMICALS** Training will be provided to all employees on the regulation and all staff will ensure all chemicals are properly labeled and locked. The program Administrator will do quarterly inspections for the home and document if chemicals are locked and properly labeled. If any chemicals are found and not locked up or labeled, immediate correction will be taken and the chemicals will be labeled and locked up. Person Responsible- RSC. Completion Date- 10/08/2010. Monitoring-QIDP, Quarterly.	

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MM271	Continued From page 3 stated the bottles contained cleaning solutions and should have been marked and locked. The facility failed to ensure all chemicals were properly labeled and locked.	MM271		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: An environmental review was conducted on 7/15/10 from 11:05 - 11:30 a.m. During that time the following was noted: - The bottom door shelf rail in the refrigerator, and the door shelf rail in the freezer, were missing in the refrigerator freezer to the left of the kitchen sink. - The padded window seat cushion in the living room was ripped and frayed all along the bottom edge. - The window blind in the bedroom shared by individual #1 and Individual #2 was broken and	MM380	**MM 380 16.03.11.120.03(a) BUILDING AND EQUIPMENT** **The Facility's maintenance person will ensure that all environmental repairs as listed in the deficiency are repaired and maintained. RSC will do weekly environmental checks to ensure maintenance in the facility is maintained.** **Person Responsible- RSC. Completion Date- 10/08/2010. Monitoring-QIDP, Quarterly.**	

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MM380	Continued From page 4 would not stay open. - Two drawer pulls on Individual #1's dresser were broken. - Three drawer pulls on Individual #3's dresser were missing screws, causing the handles to hang from the drawers. - All 4 drawers in Individual #5's dresser were broken from the rails. The facility failed to ensure environmental repairs were maintained.	MM380		
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	**MM 735 16.03.11.270.02 HEALTH SERVICES** Please refer to W 322	
MM753	16.03.11.270.02(f)(i) Locked Area All medications in the facility must be kept in a locked area(s) except during those times when the resident is receiving the medication. This Rule is not met as evidenced by: Refer to W382.	MM753	**MM 753 16.03.11.270.02(f)(i) LOCKED AREA** Please refer to W 382	

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MM757	Continued From page 5	MM757		
MM757	16.03.11.270.02(f)(iii) Signed Physician's Order No resident can receive any medication unless his record contains a current and signed physician's order for such medication. This Rule is not met as evidenced by: Refer to W368.	MM757	**MM 757 16.03.11.270.02(f)(iii) SIGNED PHYSICIAN'S ORDER** Please refer to W 368	
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W363.	MM758	**MM 758 16.03.11.270.02(f)(iv) MEDICATION SYSTEM MONITORED** Please refer to W 363	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	**MM 769 16.03.11.270.03(c)(vi) CONTROL OF COMMUNICABLE DISEASES AND INFECTION** Please refer to W 455	
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained	MM855	**MM 855 16.03.11.270.08(c) TRAINING AND HABILITATION RECORD** Please refer to W 240	

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MM855	Continued From page 6 by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W240.	MM855		